

Laborers Benefit Office

Welfare Fund

Gary Elliott
Chairman

Kenneth Karsten
Secretary Treasurer

Pension Fund

Jeffrey O'Connell
Chairman

Joseph W. Beetz
Secretary Treasurer

To: All Active Participants and Retirees other than Medicare Supplement Retirees

Date: April 2, 2009

Subject: Welfare Fund Benefit Plan Changes effective July 1, 2009

The Greater St. Louis Construction Laborers' Welfare Fund has a track record of providing high quality, comprehensive healthcare benefits to its participants. It is the Trustees' intention to continue to do that. However, the welfare fund experiences the same challenges faced by companies and other multiemployer welfare funds as healthcare costs continue to increase each year.

In the past, the Trustees have been able to manage costs in order to maintain the current very rich level of benefits while healthcare costs have spiraled out of control. The welfare fund's relationship with HealthLink has resulted in substantial discounts from healthcare providers that participate in HealthLink's extensive HMO and PPO networks. The change in the prescription drug program to MedImpact has ensured that our participants receive the best cost and value for their prescription drugs. Self-insurance of the welfare fund's healthcare benefits eliminates state insurance premium taxes and insurance company profits and allows the welfare fund to build margins to keep reserves adequate to pay benefits. Elimination of stop-loss insurance many years ago provided savings as the welfare fund no longer pays premiums to an insurance company for high dollar claims. An improved case management program provides quality care to members who experience serious illness or injuries and helps ease the experience when coping with a life changing event.

Despite all these cost containment measures, the reality is that the cost of providing medical care continues to rise. The welfare fund's consultant projects that the rate of increase in healthcare costs due to inflation, increased utilization and other factors will be 9% to 10% each year for the foreseeable future and unless benefit changes are made the welfare fund's reserves will decrease over the next three years to an unacceptable level.

As you know, this is a time of economic uncertainty. It is possible that healthcare costs will not increase at the projected rates or that a National health insurance program will solve these problems, but the Trustees cannot delay making necessary changes in hopes that things will improve without their action.

The Trustees have now determined that changes must be made to the welfare fund's benefits in order to maintain the financial stability of the welfare fund. This new plan design will increase participant cost-sharing through increased medical deductibles, increased prescription copayments and a newly added coinsurance and out-of-pocket maximum.

Although we hope these changes together with future employer contribution increases will make further benefit changes unnecessary, there is no assurance of that. The Trustees will continue to monitor the welfare fund's claim experience and financial condition and will make such changes in the future as they deem necessary to protect the financial stability of your welfare fund. Those changes might include further benefit reductions.

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A summary of the changes that will become effective medical services rendered and prescription drugs purchased on and after July 1, 2009 is attached. The summary also includes some corrections to the January 1, 2009 Summary Plan Description that you received recently.

Our membership communications efforts will be increasing to achieve positive results to participants through increased educational tools and additional home mailings. Please mark your calendar for our first Health Fair scheduled for Saturday, June 13 from 9am-1pm at the IBEW Local 1.

Please retain this Summary of Material Modifications and Reduction in Covered Services with your January 1, 2009 Summary Plan Description.

Should you have any questions about the changes that are forthcoming, contact our Customer Service department by calling 314-644-2777, extension 2.

Sincerely,

Trustees of Greater St. Louis Construction Laborers' Welfare Fund



SUMMARY OF MATERIAL MODIFICATIONS AND REDUCTION IN COVERED SERVICES

Greater St. Louis Construction Laborers' Welfare Fund

The following is a summary of the benefit changes that will become effective for medical services rendered and prescription drugs purchased on and after July 1, 2009.

Medical Benefit Changes

	Current Plan Design		New Plan Design	
	HMO & PPO Network	Non-Network	HMO & PPO Network	Non-Network
Individual Calendar Year Deductible	\$200	\$300	\$400	\$500
Family Calendar Year Deductible Maximum	\$400	\$600	\$800	\$1,000
Coinsurance	0% - HMO 10% - PPO	30%	10% - HMO 20% - PPO	40%
Out-of-Pocket Maximum	No maximum	No maximum Greater of \$15 or 30% of covered charges until you have paid \$1,500 in a calendar year. Then you must pay \$15 or 5% of covered charges; whichever is greater	\$3,000 Applicable to Individual and Family	No maximum
Office, Urgent Care and Med Stop Visits	\$15 co-pay each visit Then deductible		\$15 co-pay each visit Then deductible	Covered subject to deductible and coinsurance
Other Services in an Office Visit Setting	\$15 co-pay then deductible	Same as Above	Deductible and Coinsurance	Same as Above
Certain Preventive Services	Covered subject to deductible and coinsurance	Covered subject to deductible and coinsurance	\$15 co-pay each visit Then covered at 100% not subject to deductible or coinsurance	Covered subject to deductible and coinsurance
Hospital Emergency Room Copay	\$50	\$100	\$75	\$100
Chiropractic Visit Maximum	No maximum	\$100/day - \$1,000/year	60 visits/calendar year	\$100/day - \$1,000/year; 60 visits calendar year

Deductibles - you are responsible for the calendar year deductible before the Plan pays any benefits.

Coinsurance - is the amount you will pay after the calendar year deductible has been met. It requires you to pay either 10% or 20% after the deductible and applicable HealthLink discounts are deducted or 40% for non-network providers. Coinsurance does not apply to charges for HMO and PPO physician office visits. It does, however, apply to other services performed at the time of an office visit such as diagnostic test and therapy.

Out-of-Pocket maximum - is the maximum amount of coinsurance you and your family will pay in a calendar year (in addition to the calendar year deductible and copays).

Office visit - \$15 copay for each visit then applicable to deductible but not coinsurance (see Coinsurance above).

Certain Preventive Services - \$15 copay and the HMO/PPO deductible and coinsurance will not apply to certain medical services performed for screening purposes in accordance with generally accepted medical guidelines. These include colonoscopies, mammograms, pap smears, PSA tests and immunizations.

Deductible and out-of-pocket coinsurance expenses you incur prior to July 1, 2009 will be credited toward your new increased deductible and your out-of-pocket maximum from any claims incurred July 1 through December 31, 2009.

Prescription Drug Benefit Changes

Current Rx Plan Design	Maximum Supply	Generic	Single Source Brand	Multi-Source Brand
Retail or Mail	90 days	\$10.00	\$20.00	\$30.00
Retail	30 days	\$5.00	\$10.00	\$15.00

New Rx Plan Design	Maximum Supply	Generic	Single Source Brand	Multi-Source Brand
Retail or Mail	90 days	\$12.50	\$62.50	\$12.50 plus difference between brand and generic cost
Retail	30 days	\$5.00	\$25.00	\$5.00 plus difference between brand and generic cost

Single source brand drugs are name brand drugs that do not have a generic equivalent drug available. Multi-source brand drugs are brand name drugs that do have a generic drug available. If you purchase a brand name drug when a generic drug is available, you will be responsible for the generic copay plus the difference between the brand and generic cost. That difference may be waived if your physician provides information that documents that you have tried the generic drug and the drug did not provide the desired or expected benefit. If you are currently taking a multi-source drug, you will receive a separate communication explaining what to do in order to provide the welfare fund with documentation of your concerns with the generic alternative.

Summary Plan Description Corrections

The following was inadvertently omitted from the prescription drug section of the January 1, 2009 Summary Plan Description you received recently.

Limited Reimbursement Benefit

Generally, you must obtain your prescriptions from a participating pharmacy, must use your Plan I.D. card and must pay the required copayment amount in order to receive the Prescription Drug Benefits. However, under the very limited circumstances set forth here, the Plan will reimburse you for covered prescription drugs for which you pay the pharmacy full price.

1. If your name is omitted from the participating pharmacy's computer list of eligible participants at a time when you are, in fact, eligible, and the participating pharmacy requires you to pay for the prescription, the Plan will reimburse you for the amount it would have paid to the pharmacy if your name had been on the list and the drug was covered on the date it was dispensed.
2. If you purchase a drug from a non-participating pharmacy because you are unable to get to a participating pharmacy or you are unable to find a participating pharmacy that can provide the drug prescribed, the Plan will reimburse you for the amount it would have paid to a participating pharmacy if the drug was covered on the date it was dispensed. You should note that the network of participating pharmacies is a very extensive nationwide network with hundreds of stores in the Metropolitan St. Louis area, and you will be expected to demonstrate to the satisfaction of the Trustees that you could not, in fact, get to a participating pharmacy or get the drug in question from a participating pharmacy in order to be entitled to reimbursement.

The following was inadvertently omitted from the life insurance section of the January 1, 2009 Summary Plan Description.

Disability Extension Benefits -- Participants Only

If you become totally disabled while covered as an active participant and prior to age 65, the Trustees will pay premiums to keep your life insurance in effect until the earlier of the date (a) you attain age 65 or (b) you cease to be totally disabled.

You must present proof of total disability to the Benefit Office as soon as possible after you become disabled. After that, you must submit proof of continuation of your disability each year within three months prior to the anniversary date of the original proof of disability. Forms for providing proof of disability are available from the Benefit Office. If you do not submit the required proof of disability within the time periods stated above, your life insurance coverage will terminate.

Total Disability means your complete inability due to injury or illness, to engage in any business, occupation or employment for pay, profit or compensation, for which you are qualified or become qualified by reason of education, training or experience.